

AMENDED IN ASSEMBLY SEPTEMBER 4, 2015

AMENDED IN ASSEMBLY JULY 14, 2015

AMENDED IN SENATE APRIL 28, 2015

AMENDED IN SENATE APRIL 6, 2015

**SENATE BILL**

**No. 610**

---

**Introduced by Senator Pan**

February 27, 2015

---

An act to amend Sections 14087.325 and 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 610, as amended, Pan. Medi-Cal: federally qualified health centers: rural health clinics: managed care contracts.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis.

Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate, based on a change in the scope of services provided, as prescribed. Existing law establishes alternative ratesetting procedures with respect to a new entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC or an existing FQHC or RHC that is

relocated. Two of the procedures are referred to as comparability approaches, based on the rates of 3 similarly situated FQHCs and RHCs. The 3rd procedure requires, at a new entity's one-time election, that the department establish the reimbursement rate, calculated on a per-visit basis, that equals 100% of the projected allowable costs to the FQHC or RHC of furnishing services during its first 12 months of operation as an FQHC or RHC.

This bill would require the department to finalize a new rate within 1 year after an FQHC's or RHC's submission of a scope-of-service rate change. With respect to a new FQHC or RHC that has elected for the department to establish its reimbursement rate based on projected allowable costs as described above, this bill would require the department to finalize that rate within 1 year after the submission of the actual cost report from the first full 12 months of operation, as specified.

This bill would revise the department's responsibilities with respect to a new entity or a relocated FQHC or RHC that selects either of the comparability approaches. The bill would require the department to review the comparable facilities to determine if any of them do not meet the comparability threshold and, if so, to notify the new entity, and request a supplemental submission, as prescribed. The bill would require the department to conduct an initial review of a scope-of-service rate change request within 30 days after submission by the FQHC or RHC, and notify the FQHC or RHC by the 31st day after submission if the department determines that additional information is necessary, as prescribed. The bill would require the department to finalize the FQHC's or RHC's rate within 1 year after receiving a submission the department determines to be complete.

This bill would require the department to correct erroneous payments at least quarterly to reprocess past claims and ensure all claims are reimbursed at the appropriate finalized new rate.

Existing law requires the department to administer a program to ensure that total payments to FQHCs and RHCs operating as managed care subcontractors comply with applicable federal law regarding payment for services provided by FQHCs and RHCs. Under the department's program, existing law requires FQHCs and RHCs subcontracting with specified managed care plans to seek supplemental reimbursement from the department through a per visit fee-for-service billing system. To be reimbursed under these provisions, existing law requires each FQHC and RHC to submit to the department for approval a rate differential

based on the FQHC's or RHC's reasonable cost or the prospective payment rate. Within 6 months of the end of the FQHC's or RHC's fiscal year, existing law requires, to the extent feasible, the department to perform an annual reconciliation to reasonable cost, and make payments to, or obtain recovery from, the FQHC or RHC.

This bill would impose various requirements on the department regarding the reconciliation process described above. The bill would require the department to complete the final reconciliation review and pay to the center or clinic any remaining amount owed within 18 months after the last date of the fiscal year for which the department is conducting the review.

*This bill would incorporate additional changes to Section 14132.100 of the Welfare and Institutions Code made by this bill and AB 858 to take effect if both bills are chaptered and this bill is chaptered last.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 14087.325 of the Welfare and Institutions  
2 Code is amended to read:  
3 14087.325. (a) The department shall require, as a condition  
4 of obtaining a contract with the department, that any local initiative,  
5 as defined in Section 53810 of Title 22 of the California Code of  
6 Regulations, offer a subcontract to any entity defined in Section  
7 1396d(l)(2)(B) of Title 42 of the United States Code providing  
8 services as defined in Section 1396d(a)(2)(C) of Title 42 of the  
9 United States Code and operating in the service area covered by  
10 the local initiative's contract with the department. These entities  
11 are also known as federally qualified health centers.  
12 (b) Except as otherwise provided in this section, managed care  
13 subcontracts offered to a federally qualified health center or a rural  
14 health clinic, as defined in Section 1396d(l)(1) of Title 42 of the  
15 United States Code, by a local initiative, county organized health  
16 system, as defined in Section 12693.05 of the Insurance Code,  
17 commercial plan, as defined in Section 53810 of Title 22 of the  
18 California Code of Regulations, or a health plan contracting with  
19 a geographic managed care program, as defined in subdivision (g)  
20 of Section 53902 of Title 22 of the California Code of Regulations,  
21 shall be on the same terms and conditions offered to other

1 subcontractors providing a similar scope of service. Any  
2 beneficiary, subscriber, or enrollee of a program or plan who  
3 affirmatively selects, or is assigned by default to, a federally  
4 qualified health center or rural health clinic under the terms of a  
5 contract between a plan, government program, or any subcontractor  
6 of a plan or program, and a federally qualified health center or  
7 rural health clinic, shall be assigned directly to the federally  
8 qualified health center or rural health clinic, and not to any  
9 individual provider performing services on behalf of the federally  
10 qualified health center or rural health clinic.

11 (c) The department shall provide incentives in the competitive  
12 application process described in paragraph (1) of subdivision (b)  
13 of Section 53800 of Title 22 of the California Code of Regulations,  
14 to encourage potential commercial plans as defined in Section  
15 53810 of Title 22 of the California Code of Regulations to offer  
16 subcontracts to these federally qualified health centers.

17 (d) Reimbursement to federally qualified health centers and  
18 rural health centers for services provided pursuant to a subcontract  
19 with a local initiative, a commercial plan, geographic managed  
20 care program health plan, or a county organized health system,  
21 shall be paid in a manner that is not less than the level and amount  
22 of payment that the plan would make for the same scope of services  
23 if the services were furnished by a provider that is not a federally  
24 qualified health center or rural health clinic.

25 (e) The department shall administer a program to ensure that  
26 total payments to federally qualified health centers and rural health  
27 clinics operating as managed care subcontractors pursuant to  
28 subdivision (d) comply with applicable federal law pursuant to  
29 Sections 1902(bb) and 1903(m)(2)(A)(ix) of the Social Security  
30 Act (42 U.S.C. Secs. 1396a(bb) and 1396b(m)(2)(A)(ix)). Under  
31 the department's program, federally qualified health centers and  
32 rural health clinics subcontracting with local initiatives, commercial  
33 plans, county organized health systems, and geographic managed  
34 care program health plans shall seek supplemental reimbursement  
35 from the department through a per visit fee-for-service billing  
36 system utilizing the state's Medi-Cal fee-for-service claims  
37 processing system contractor. To carry out this per visit payment  
38 process, each federally qualified health system and rural health  
39 clinic shall submit to the department for approval a rate differential  
40 calculated to reflect the amount necessary to reimburse the federally

1 qualified health center or rural health clinic for the difference  
2 between the payment the center or clinic received from the  
3 managed care health plan and either the interim rate established  
4 by the department based on the center's or clinic's reasonable cost  
5 or the center's or clinic's prospective payment rate. The department  
6 shall adjust the computed rate differential as it deems necessary  
7 to minimize the difference between the center's or clinic's revenue  
8 from the plan and the center's or clinic's cost-based reimbursement  
9 or the center's or clinic's prospective payment rate.

10 (1) In addition, the department shall perform an annual  
11 reconciliation to reasonable cost, and make payments to, or obtain  
12 a recovery from, the center or clinic.

13 (2) The department shall perform an initial review of the  
14 reconciliation filing within 30 days after receipt. If the department  
15 determines during the initial review that a payment is owed to the  
16 center or clinic, the department shall pay to the center or clinic at  
17 least 80 percent of the amount owed within 30 days after  
18 completion of the initial review or in any event within 60 days  
19 after receipt of the reconciliation filing.

20 (3) The department shall complete the final reconciliation review  
21 and shall pay to the center or clinic the remaining amount owed  
22 within 18 months after the last date of the fiscal year for which  
23 the department is conducting the review.

24 (f) In calculating the capitation rates to be paid to local  
25 initiatives, commercial plans, geographic managed care program  
26 health plans, and county organized health systems, the department  
27 shall not include the additional dollar amount applicable to  
28 cost-based reimbursement that would otherwise be paid, absent  
29 cost-based reimbursement, to federally qualified health centers  
30 and rural health clinics in the Medi-Cal fee-for-service program.

31 (g) On or before September 30, 2002, the director shall conduct  
32 a study of the actual and projected impact of the transition from a  
33 cost-based reimbursement system to a prospective payment system  
34 for federally qualified health centers and rural health clinics. In  
35 conducting the study, the director shall evaluate the extent to which  
36 the prospective payment system stimulates expansion of services,  
37 including new facilities to expand capacity of the centers, and the  
38 extent to which actual and estimated prospective payment rates of  
39 federally qualified health centers and rural health clinics for the  
40 first five years of the prospective payment system are reflective

1 of the cost of providing services to Medi-Cal beneficiaries. Clinics  
2 may submit cost reporting information to the department to provide  
3 data for the study.

4 (h) The department shall approve all contracts between federally  
5 qualified health centers or rural health clinics and any local  
6 initiative, commercial plan, geographic managed care program  
7 health plan, or county organized health system in order to ensure  
8 compliance with this section.

9 (i) This section shall not preclude the department from  
10 establishing pilot programs pursuant to Section 14087.329.

11 SEC. 2. Section 14132.100 of the Welfare and Institutions  
12 Code is amended to read:

13 14132.100. (a) The federally qualified health center services  
14 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
15 Code are covered benefits.

16 (b) The rural health clinic services described in Section  
17 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
18 benefits.

19 (c) Federally qualified health center services and rural health  
20 clinic services shall be reimbursed on a per-visit basis in  
21 accordance with the definition of “visit” set forth in subdivision  
22 (g).

23 (d) Effective October 1, 2004, and on each October 1 thereafter,  
24 until no longer required by federal law, federally qualified health  
25 center (FQHC) and rural health clinic (RHC) per-visit rates shall  
26 be increased by the Medicare Economic Index applicable to  
27 primary care services in the manner provided for in Section  
28 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
29 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted  
30 by the Medicare Economic Index in accordance with the  
31 methodology set forth in the state plan in effect on October 1,  
32 2001.

33 (e) (1) An FQHC or RHC may apply for an adjustment to its  
34 per-visit rate based on a change in the scope of services provided  
35 by the FQHC or RHC. Rate changes based on a change in the  
36 scope of services provided by an FQHC or RHC shall be evaluated  
37 in accordance with Medicare reasonable cost principles, as set  
38 forth in Part 413 (commencing with Section 413.1) of Title 42 of  
39 the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

1 (C) The change in the scope of services is a change in the type,  
2 intensity, duration, or amount of services, or any combination  
3 thereof.

4 (D) The net change in the FQHC's or RHC's rate equals or  
5 exceeds 1.75 percent for the affected FQHC or RHC site. For  
6 FQHCs and RHCs that filed consolidated cost reports for multiple  
7 sites to establish the initial prospective payment reimbursement  
8 rate, the 1.75-percent threshold shall be applied to the average  
9 per-visit rate of all sites for the purposes of calculating the cost  
10 associated with a scope-of-service change. "Net change" means  
11 the per-visit rate change attributable to the cumulative effect of all  
12 increases and decreases for a particular fiscal year.

13 (4) An FQHC or RHC may submit requests for scope-of-service  
14 changes once per fiscal year, only within 90 days following the  
15 beginning of the FQHC's or RHC's fiscal year. Any approved  
16 increase or decrease in the provider's rate shall be retroactive to  
17 the beginning of the FQHC's or RHC's fiscal year in which the  
18 request is submitted.

19 (5) An FQHC or RHC shall submit a scope-of-service rate  
20 change request within 90 days after the beginning of any FQHC  
21 or RHC fiscal year occurring after the effective date of this section,  
22 if, during the FQHC's or RHC's prior fiscal year, the FQHC or  
23 RHC experienced a decrease in the scope of services provided that  
24 the FQHC or RHC either knew or should have known would have  
25 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
26 discontinues providing onsite pharmacy or dental services, it shall  
27 submit a scope-of-service rate change request within 90 days after  
28 the beginning of the following fiscal year. The rate change shall  
29 be effective as provided for in paragraph (4). As used in this  
30 paragraph, "significantly lower" means an average per-visit rate  
31 decrease in excess of 2.5 percent.

32 (6) (A) The department shall conduct an initial review of a  
33 scope-of-service rate change request within 30 days after  
34 submission by an FQHC or RHC.

35 (B) If the department determines that additional information is  
36 necessary to finalize a new rate, the department shall notify the  
37 FQHC or RHC, no later than the 31st day after submission. The  
38 notification shall state the reason or reasons the submitted  
39 information is insufficient and shall request submission of  
40 supplemental information from the FQHC or RHC.



1 (C) Within one year after receiving a submission that it  
2 determines to be complete, the department shall finalize the  
3 FQHC's or RHC's rate and shall update the provider master file  
4 within 10 business days.

5 (7) Notwithstanding paragraph (4), if the approved  
6 scope-of-service change or changes were initially implemented  
7 on or after the first day of an FQHC's or RHC's fiscal year ending  
8 in calendar year 2001, but before the adoption and issuance of  
9 written instructions for applying for a scope-of-service change,  
10 the adjusted reimbursement rate for that scope-of-service change  
11 shall be made retroactive to the date the scope-of-service change  
12 was initially implemented. Scope-of-service changes under this  
13 paragraph shall be required to be submitted within the later of 150  
14 days after the adoption and issuance of the written instructions by  
15 the department, or 150 days after the end of the FQHC's or RHC's  
16 fiscal year ending in 2003.

17 (8) All references in this subdivision to "fiscal year" shall be  
18 construed to be references to the fiscal year of the individual FQHC  
19 or RHC, as the case may be.

20 (f) (1) An FQHC or RHC may request a supplemental payment  
21 if extraordinary circumstances beyond the control of the FQHC  
22 or RHC occur after December 31, 2001, and PPS payments are  
23 insufficient due to these extraordinary circumstances. Supplemental  
24 payments arising from extraordinary circumstances under this  
25 subdivision shall be solely and exclusively within the discretion  
26 of the department and shall not be subject to subdivision (l). These  
27 supplemental payments shall be determined separately from the  
28 scope-of-service adjustments described in subdivision (e).  
29 Extraordinary circumstances include, but are not limited to, acts  
30 of nature, changes in applicable requirements in the Health and  
31 Safety Code, changes in applicable licensure requirements, and  
32 changes in applicable rules or regulations. Mere inflation of costs  
33 alone, absent extraordinary circumstances, shall not be grounds  
34 for supplemental payment. If an FQHC's or RHC's PPS rate is  
35 sufficient to cover its overall costs, including those associated with  
36 the extraordinary circumstances, then a supplemental payment is  
37 not warranted.

38 (2) The department shall accept requests for supplemental  
39 payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars (\$200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

1 (2) (A) A visit shall also include a face-to-face encounter  
2 between an FQHC or RHC patient and a dental hygienist or a  
3 dental hygienist in alternative practice.

4 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
5 currently includes the cost of the services of a dental hygienist in  
6 alternative practice for the purposes of establishing its FQHC or  
7 RHC rate shall apply for an adjustment to its per-visit rate, and,  
8 after the rate adjustment has been approved by the department,  
9 shall bill these services as a separate visit. However, multiple  
10 encounters with dental professionals that take place on the same  
11 day shall constitute a single visit. The department shall develop  
12 the appropriate forms to determine which FQHC's or RHC's rates  
13 shall be adjusted and to facilitate the calculation of the adjusted  
14 rates. An FQHC's or RHC's application for, or the department's  
15 approval of, a rate adjustment pursuant to this subparagraph shall  
16 not constitute a change in scope of service within the meaning of  
17 subdivision (e). An FQHC or RHC that applies for an adjustment  
18 to its rate pursuant to this subparagraph may continue to bill for  
19 all other FQHC or RHC visits at its existing per-visit rate, subject  
20 to reconciliation, until the rate adjustment for visits between an  
21 FQHC or RHC patient and a dental hygienist or a dental hygienist  
22 in alternative practice has been approved. Any approved increase  
23 or decrease in the provider's rate shall be made within six months  
24 after the date of receipt of the department's rate adjustment forms  
25 pursuant to this subparagraph and shall be retroactive to the  
26 beginning of the fiscal year in which the FQHC or RHC submits  
27 the request, but in no case shall the effective date be earlier than  
28 January 1, 2008.

29 (C) An FQHC or RHC that does not provide dental hygienist  
30 or dental hygienist in alternative practice services, and later elects  
31 to add these services, shall process the addition of these services  
32 as a change in scope of service pursuant to subdivision (e).

33 (h) If FQHC or RHC services are partially reimbursed by a  
34 third-party payer, such as a managed care entity (as defined in  
35 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
36 the Medicare Program, or the Child Health and Disability  
37 Prevention (CHDP) program, the department shall reimburse an  
38 FQHC or RHC for the difference between its per-visit PPS rate  
39 and receipts from other plans or programs on a contract-by-contract  
40 basis and not in the aggregate, and may not include managed care

1 financial incentive payments that are required by federal law to  
2 be excluded from the calculation.

3 (i) (1) An entity that first qualifies as an FQHC or RHC in the  
4 year 2001 or later, a newly licensed facility at a new location added  
5 to an existing FQHC or RHC, and any entity that is an existing  
6 FQHC or RHC that is relocated to a new site shall each have its  
7 reimbursement rate established in accordance with one of the  
8 following methods, as selected by the FQHC or RHC:

9 (A) The rate may be calculated on a per-visit basis in an amount  
10 that is equal to the average of the per-visit rates of three comparable  
11 FQHCs or RHCs located in the same or adjacent area with a similar  
12 caseload.

13 (B) In the absence of three comparable FQHCs or RHCs with  
14 a similar caseload, the rate may be calculated on a per-visit basis  
15 in an amount that is equal to the average of the per-visit rates of  
16 three comparable FQHCs or RHCs located in the same or an  
17 adjacent service area, or in a reasonably similar geographic area  
18 with respect to relevant social, health care, and economic  
19 characteristics.

20 (C) At a new entity's one-time election, the department shall  
21 establish a reimbursement rate, calculated on a per-visit basis, that  
22 is equal to 100 percent of the projected allowable costs to the  
23 FQHC or RHC of furnishing FQHC or RHC services during the  
24 first 12 months of operation as an FQHC or RHC. After the first  
25 12-month period, the projected per-visit rate shall be increased by  
26 the Medicare Economic Index (MEI) then in effect. The projected  
27 allowable costs for the first 12 months shall be cost settled and the  
28 prospective payment reimbursement rate shall be adjusted based  
29 on actual and allowable cost per visit. The department shall finalize  
30 a new rate within one year after the submission of the actual cost  
31 report from the first full 12 months of operation and shall update  
32 the department provider master file within 10 business days after  
33 finalizing the rate.

34 (D) The department may adopt any further and additional  
35 methods of setting reimbursement rates for newly qualified FQHCs  
36 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
37 of the United States Code.

38 (2) (A) In order for an FQHC or RHC to establish the  
39 comparability of its caseload, the department shall require that the  
40 FQHC or RHC submit its most recent annual utilization report as

submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs. This paragraph shall apply only to a facility that selects the comparability approach described in subparagraph (A) or (B) of paragraph (1).

(B) The department shall conduct an initial review of the three FQHCs or RHCs for the purpose of determining comparability within 30 days after submission by the new entity. If the department determines one or more of the submitted centers or clinics do not meet the comparability threshold, the department shall notify the new entity no later than the 31st day after submission.

(C) The notification shall state the reason or reasons for the finding of noncomparability and shall request a supplemental submission from the new entity. The request shall clearly state whether the new entity shall submit data from one, two, or three FQHCs or RHCs to meet the comparability threshold. Once the new entity submits its supplemental information, the initial review process described in subparagraph (B) shall apply.

(D) Within one year after receiving a submission determined by the department to be comparable, the department shall finalize the new entity's rate and shall update the provider master file within 10 business days.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis until it is informed of its

1 enrollment as an FQHC or RHC, and the department shall reconcile  
2 the difference between the fee-for-service payments and the  
3 FQHC's or RHC's prospective payment rate at that time.

4 (j) Visits occurring at an intermittent clinic site, as defined in  
5 subdivision (h) of Section 1206 of the Health and Safety Code, of  
6 an existing FQHC or RHC, or in a mobile unit as defined by  
7 paragraph (2) of subdivision (b) of Section 1765.105 of the Health  
8 and Safety Code, shall be billed by and reimbursed at the same  
9 rate as the FQHC or RHC establishing the intermittent clinic site  
10 or the mobile unit, subject to the right of the FQHC or RHC to  
11 request a scope-of-service adjustment to the rate.

12 (k) An FQHC or RHC may elect to have pharmacy or dental  
13 services reimbursed on a fee-for-service basis, utilizing the current  
14 fee schedules established for those services. These costs shall be  
15 adjusted out of the FQHC's or RHC's clinic base rate as  
16 scope-of-service changes. An FQHC or RHC that reverses its  
17 election under this subdivision shall revert to its prior rate, subject  
18 to an increase to account for all MEI increases occurring during  
19 the intervening time period, and subject to any increase or decrease  
20 associated with applicable scope-of-services adjustments as  
21 provided in subdivision (e).

22 (l) FQHCs and RHCs may appeal a grievance or complaint  
23 concerning ratesetting, scope-of-service changes, and settlement  
24 of cost report audits, in the manner prescribed by Section 14171.  
25 The rights and remedies provided under this subdivision are  
26 cumulative to the rights and remedies available under all other  
27 provisions of law of this state.

28 (m) The department shall, by no later than March 30, 2008,  
29 promptly seek all necessary federal approvals in order to implement  
30 this section, including any amendments to the state plan. To the  
31 extent that any element or requirement of this section is not  
32 approved, the department shall submit a request to the federal  
33 Centers for Medicare and Medicaid Services for any waivers that  
34 would be necessary to implement this section.

35 (n) The department shall implement this section only to the  
36 extent that federal financial participation is obtained.

37 (o) The department shall correct erroneous payments at least  
38 quarterly to reprocess past claims and ensure all claims are  
39 reimbursed at the finalized new rate determined pursuant to either  
40 subdivision (e) or (i).

1     *SEC. 2.1. Section 14132.100 of the Welfare and Institutions*  
2     *Code is amended to read:*

3     14132.100. (a) The federally qualified health center services  
4     described in Section 1396d(a)(2)(C) of Title 42 of the United States  
5     Code are covered benefits.

6     (b) The rural health clinic services described in Section  
7     1396d(a)(2)(B) of Title 42 of the United States Code are covered  
8     benefits.

9     (c) Federally qualified health center services and rural health  
10    clinic services shall be reimbursed on a per-visit basis in  
11    accordance with the definition of “visit” set forth in subdivision  
12    (g).

13    (d) Effective October 1, 2004, and on each October—~~1~~, *I*  
14    thereafter, until no longer required by federal law, federally  
15    qualified health center (FQHC) and rural health clinic (RHC)  
16    per-visit rates shall be increased by the Medicare Economic Index  
17    applicable to primary care services in the manner provided for in  
18    Section 1396a(bb)(3)(A) of Title 42 of the United States Code.  
19    Prior to January 1, 2004, FQHC and RHC per-visit rates shall be  
20    adjusted by the Medicare Economic Index in accordance with the  
21    methodology set forth in the state plan in effect on October 1,  
22    2001.

23    (e) (1) An FQHC or RHC may apply for an adjustment to its  
24    per-visit rate based on a change in the scope of services provided  
25    by the FQHC or RHC. Rate changes based on a change in the  
26    scope of services provided by an FQHC or RHC shall be evaluated  
27    in accordance with Medicare reasonable cost principles, as set  
28    forth in Part 413 (commencing with Section 413.1) of Title 42 of  
29    the Code of Federal Regulations, or its successor.

30    (2) Subject to the conditions set forth in subparagraphs (A) to  
31    (D), inclusive, of paragraph (3), a change in scope of service means  
32    any of the following:

33    (A) The addition of a new FQHC or RHC service that is not  
34    incorporated in the baseline prospective payment system (PPS)  
35    rate, or a deletion of an FQHC or RHC service that is incorporated  
36    in the baseline PPS rate.

37    (B) A change in service due to amended regulatory requirements  
38    or rules.

39    (C) A change in service resulting from relocating or remodeling  
40    an FQHC or RHC.

1 (D) A change in types of services due to a change in applicable  
2 technology and medical practice utilized by the center or clinic.

3 (E) An increase in service intensity attributable to changes in  
4 the types of patients served, including, but not limited to,  
5 populations with HIV or AIDS, or other chronic diseases, or  
6 homeless, elderly, migrant, or other special populations.

7 (F) Any changes in any of the services described in subdivision  
8 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
9 its sites.

10 (G) Changes in operating costs attributable to capital  
11 expenditures associated with a modification of the scope of any  
12 of the services described in subdivision (a) or (b), including new  
13 or expanded service facilities, regulatory compliance, or changes  
14 in technology or medical practices at the center or clinic.

15 (H) Indirect medical education adjustments and a direct graduate  
16 medical education payment that reflects the costs of providing  
17 teaching services to interns and residents.

18 (I) Any changes in the scope of a project approved by the federal  
19 Health Resources and ~~Service~~ *Services* Administration (HRSA).

20 (3) No change in costs shall, in and of itself, be considered a  
21 scope-of-service change unless all of the following apply:

22 (A) The increase or decrease in cost is attributable to an increase  
23 or decrease in the scope of services defined in subdivisions (a) and  
24 (b), as applicable.

25 (B) The cost is allowable under Medicare reasonable cost  
26 principles set forth in Part 413 (commencing with Section 413) of  
27 Subchapter B of Chapter 4 of Title 42 of the Code of Federal  
28 Regulations, or its successor.

29 (C) The change in the scope of services is a change in the type,  
30 intensity, duration, or amount of services, or any combination  
31 thereof.

32 (D) The net change in the FQHC's or RHC's rate equals or  
33 exceeds 1.75 percent for the affected FQHC or RHC site. For  
34 FQHCs and RHCs that filed consolidated cost reports for multiple  
35 sites to establish the initial prospective payment reimbursement  
36 rate, the 1.75-percent threshold shall be applied to the average  
37 per-visit rate of all sites for the purposes of calculating the cost  
38 associated with a scope-of-service change. "Net change" means  
39 the per-visit rate change attributable to the cumulative effect of all  
40 increases and decreases for a particular fiscal year.



(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days ~~of~~ *after* the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days ~~of~~ *after* the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) (A) *The department shall conduct an initial review of a scope-of-service rate change request within 30 days after submission by an FQHC or RHC.*

(B) *If the department determines that additional information is necessary to finalize a new rate, the department shall notify the FQHC or RHC, no later than the 31st day after submission. The notification shall state the reason or reasons the submitted information is insufficient and shall request submission of supplemental information from the FQHC or RHC.*

(C) *Within one year after receiving a submission that it determines to be complete, the department shall finalize the FQHC's or RHC's rate and shall update the provider master file within 10 business days.*

~~(6)~~

(7) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change

1 was initially implemented. Scope-of-service changes under this  
2 paragraph shall be required to be submitted within the later of 150  
3 days after the adoption and issuance of the written instructions by  
4 the department, or 150 days after the end of the FQHC's or RHC's  
5 fiscal year ending in 2003.

6 ~~(7)~~

7 (8) All references in this subdivision to "fiscal year" shall be  
8 construed to be references to the fiscal year of the individual FQHC  
9 or RHC, as the case may be.

10 (f) (1) An FQHC or RHC may request a supplemental payment  
11 if extraordinary circumstances beyond the control of the FQHC  
12 or RHC occur after December 31, 2001, and PPS payments are  
13 insufficient due to these extraordinary circumstances. Supplemental  
14 payments arising from extraordinary circumstances under this  
15 subdivision shall be solely and exclusively within the discretion  
16 of the department and shall not be subject to subdivision (l). These  
17 supplemental payments shall be determined separately from the  
18 scope-of-service adjustments described in subdivision (e).  
19 Extraordinary circumstances include, but are not limited to, acts  
20 of nature, changes in applicable requirements in the Health and  
21 Safety Code, changes in applicable licensure requirements, and  
22 changes in applicable rules or regulations. Mere inflation of costs  
23 alone, absent extraordinary circumstances, shall not be grounds  
24 for supplemental payment. If an FQHC's or RHC's PPS rate is  
25 sufficient to cover its overall costs, including those associated with  
26 the extraordinary circumstances, then a supplemental payment is  
27 not warranted.

28 (2) The department shall accept requests for supplemental  
29 payment at any time throughout the prospective payment rate year.

30 (3) Requests for supplemental payments shall be submitted in  
31 writing to the department and shall set forth the reasons for the  
32 request. Each request shall be accompanied by sufficient  
33 documentation to enable the department to act upon the request.  
34 Documentation shall include the data necessary to demonstrate  
35 that the circumstances for which supplemental payment is requested  
36 meet the requirements set forth in this section. Documentation  
37 shall include all of the following:

38 (A) A presentation of data to demonstrate reasons for the  
39 FQHC's or RHC's request for a supplemental payment.

1 (B) Documentation showing the cost implications. The cost  
2 impact shall be material and significant, two hundred thousand  
3 dollars (\$200,000) or 1 percent of a facility's total costs, whichever  
4 is less.

5 (4) A request shall be submitted for each affected year.

6 (5) Amounts granted for supplemental payment requests shall  
7 be paid as lump-sum amounts for those years and not as revised  
8 PPS rates, and shall be repaid by the FQHC or RHC to the extent  
9 that it is not expended for the specified purposes.

10 (6) The department shall notify the provider of the department's  
11 discretionary decision in writing.

12 (g) (1) An FQHC or RHC "visit" means a face-to-face  
13 encounter between an FQHC or RHC patient and a physician,  
14 physician assistant, nurse practitioner, certified nurse-midwife,  
15 clinical psychologist, licensed clinical social worker, or a visiting  
16 nurse. For purposes of this section, "physician" shall be interpreted  
17 in a manner consistent with the *federal* Centers for Medicare and  
18 Medicaid Services' Medicare Rural Health Clinic and Federally  
19 Qualified Health Center Manual (Publication 27), or its successor,  
20 only to the extent that it defines the professionals whose services  
21 are reimbursable on a per-visit basis and not as to the types of  
22 services that these professionals may render during these visits  
23 and shall include a ~~physician and surgeon~~, *medical doctor*,  
24 *osteopath*, podiatrist, dentist, optometrist, and chiropractor. A visit  
25 shall also include a face-to-face encounter between an FQHC or  
26 RHC patient and a comprehensive perinatal-services practitioner,  
27 as defined in Section ~~51179.4~~ *51179.7* of Title 22 of the California  
28 Code of Regulations, providing comprehensive perinatal services,  
29 a four-hour day of attendance at an adult day health care center,  
30 and any other provider identified in the state plan's definition of  
31 an FQHC or RHC visit.

32 (2) (A) A visit shall also include a face-to-face encounter  
33 between an FQHC or RHC patient and a dental ~~hygienist or~~  
34 *hygienist*, a dental hygienist in alternative ~~practice~~, *practice, or a*  
35 *marriage and family therapist*.

36 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
37 currently includes the cost of the services of a dental hygienist in  
38 alternative ~~practice~~ *practice, or a marriage and family therapist*,  
39 for the purposes of establishing its FQHC or RHC rate shall apply  
40 for an adjustment to its per-visit rate, and, after the rate adjustment

1 has been approved by the department, shall bill these services as  
2 a separate visit. However, multiple encounters with dental  
3 professionals *or marriage and family therapists* that take place on  
4 the same day shall constitute a single visit. The department shall  
5 develop the appropriate forms to determine which FQHC's or RHC  
6 RHC's rates shall be adjusted and to facilitate the calculation of  
7 the adjusted rates. An FQHC's or RHC's application for, or the  
8 department's approval of, a rate adjustment pursuant to this  
9 subparagraph shall not constitute a change in scope of service  
10 within the meaning of subdivision (e). An FQHC or RHC that  
11 applies for an adjustment to its rate pursuant to this subparagraph  
12 may continue to bill for all other FQHC or RHC visits at its existing  
13 per-visit rate, subject to reconciliation, until the rate adjustment  
14 for visits between an FQHC or RHC patient and a dental hygienist  
15 ~~or hygienist~~, a dental hygienist in alternative ~~practice~~ practice, *or*  
16 *a marriage and family therapist* has been approved. Any approved  
17 increase or decrease in the provider's rate shall be made within  
18 six months after the date of receipt of the department's rate  
19 adjustment forms pursuant to this subparagraph and shall be  
20 retroactive to the beginning of the fiscal year in which the FQHC  
21 or RHC submits the request, but in no case shall the effective date  
22 be earlier than January 1, 2008.

23 (C) An FQHC or RHC that does not provide dental ~~hygienist~~  
24 ~~or hygienist~~, dental hygienist in alternative ~~practice~~ practice, *or*  
25 *marriage and family therapist* services, and later elects to add these  
26 services, shall process the addition of these services as a change  
27 in scope of service pursuant to subdivision (e).

28 (h) If FQHC or RHC services are partially reimbursed by a  
29 third-party payer, such as a managed care entity (as defined in  
30 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
31 the Medicare ~~Program~~, program, or the Child Health and Disability  
32 Prevention (CHDP) program, the department shall reimburse an  
33 FQHC or RHC for the difference between its per-visit PPS rate  
34 and receipts from other plans or programs on a contract-by-contract  
35 basis and not in the aggregate, and may not include managed care  
36 financial incentive payments that are required by federal law to  
37 be excluded from the calculation.

38 (i) (1) An entity that first qualifies as an FQHC or RHC in the  
39 year 2001 or later, a newly licensed facility at a new location added  
40 to an existing FQHC or RHC, and any entity that is an existing

1 FQHC or RHC that is relocated to a new site shall each have its  
2 reimbursement rate established in accordance with one of the  
3 following methods, as selected by the FQHC or RHC:

4 (A) The rate may be calculated on a per-visit basis in an amount  
5 that is equal to the average of the per-visit rates of three comparable  
6 FQHCs or RHCs located in the same or adjacent area with a similar  
7 caseload.

8 (B) In the absence of three comparable FQHCs or RHCs with  
9 a similar caseload, the rate may be calculated on a per-visit basis  
10 in an amount that is equal to the average of the per-visit rates of  
11 three comparable FQHCs or RHCs located in the same or an  
12 adjacent service area, or in a reasonably similar geographic area  
13 with respect to relevant social, health care, and economic  
14 characteristics.

15 (C) At a new entity's one-time election, the department shall  
16 establish a reimbursement rate, calculated on a per-visit basis, that  
17 is equal to 100 percent of the projected allowable costs to the  
18 FQHC or RHC of furnishing FQHC or RHC services during the  
19 first 12 months of operation as an FQHC or RHC. After the first  
20 12-month period, the projected per-visit rate shall be increased by  
21 the Medicare Economic Index (*MEI*) then in effect. The projected  
22 allowable costs for the first 12 months shall be cost settled and the  
23 prospective payment reimbursement rate shall be adjusted based  
24 on actual and allowable cost per visit. *The department shall finalize*  
25 *a new rate within one year after the submission of the actual cost*  
26 *report from the first full 12 months of operation and shall update*  
27 *the department provider master file within 10 business days after*  
28 *finalizing the rate.*

29 (D) The department may adopt any further and additional  
30 methods of setting reimbursement rates for newly qualified FQHCs  
31 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
32 of the United States Code.

33 (2) (A) In order for an FQHC or RHC to establish the  
34 comparability of its caseload for purposes of subparagraph (A) or  
35 (B) of paragraph (1), *caseload*, the department shall require that  
36 the FQHC or RHC submit its most recent annual utilization report  
37 as submitted to the Office of Statewide Health Planning and  
38 Development, unless the FQHC or RHC was not required to file  
39 an annual utilization report. FQHCs or RHCs that have experienced  
40 changes in their services or caseload subsequent to the filing of

1 the annual utilization report may submit to the department a  
2 completed report in the format applicable to the prior calendar  
3 year. FQHCs or RHCs that have not previously submitted an annual  
4 utilization report shall submit to the department a completed report  
5 in the format applicable to the prior calendar year. The FQHC or  
6 RHC shall not be required to submit the annual utilization report  
7 for the comparable FQHCs or RHCs to the department, but shall  
8 be required to identify the comparable FQHCs or RHCs. *This*  
9 *paragraph shall apply only to a facility that selects the*  
10 *comparability approach described in subparagraph (A) or (B) of*  
11 *paragraph (1).*

12 (B) *The department shall conduct an initial review of the three*  
13 *FQHCs or RHCs for the purpose of determining comparability*  
14 *within 30 days after submission by the new entity. If the department*  
15 *determines one or more of the submitted centers or clinics do not*  
16 *meet the comparability threshold, the department shall notify the*  
17 *new entity no later than the 31st day after submission.*

18 (C) *The notification shall state the reason or reasons for the*  
19 *finding of noncomparability and shall request a supplemental*  
20 *submission from the new entity. The request shall clearly state*  
21 *whether the new entity shall submit data from one, two, or three*  
22 *FQHCs or RHCs to meet the comparability threshold. Once the*  
23 *new entity submits its supplemental information, the initial review*  
24 *process described in subparagraph (B) shall apply.*

25 (D) *Within one year after receiving a submission determined*  
26 *by the department to be comparable, the department shall finalize*  
27 *the new entity's rate and shall update the provider master file*  
28 *within 10 business days.*

29 (3) The rate for any newly qualified entity set forth under this  
30 subdivision shall be effective retroactively to the later of the date  
31 that the entity was first qualified by the applicable federal agency  
32 as an FQHC or RHC, the date a new facility at a new location was  
33 added to an existing FQHC or RHC, or the date on which an  
34 existing FQHC or RHC was relocated to a new site. The FQHC  
35 or RHC shall be permitted to continue billing for Medi-Cal covered  
36 benefits on a fee-for-service basis *under its existing provider*  
37 *number*, until it is informed of its ~~enrollment as an FQHC or RHC;~~  
38 *RHC enrollment approval*, and the department shall reconcile the  
39 difference between the fee-for-service payments and the FQHC's  
40 or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all ~~MEI~~ *Medicare Economic Index* increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable ~~scope-of-services~~ *scope-of-service* adjustments as provided in subdivision (e).

(l) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, ~~by~~ no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

(o) *The department shall correct erroneous payments at least quarterly to reprocess past claims and ensure all claims are reimbursed at the finalized new rate determined pursuant to either subdivision (e) or (i).*

*SEC. 3. Section 2.1 of this bill incorporates amendments to Section 14132.100 of the Welfare and Institutions Code proposed*

1 *by both this bill and Assembly Bill 858. It shall only become*  
2 *operative if (1) both bills are enacted and become effective on or*  
3 *before January 1, 2016, (2) each bill amends Section 14132.100*  
4 *of the Welfare and Institutions Code, and (3) this bill is enacted*  
5 *after Assembly Bill 858, in which case Section 2 of this bill shall*  
6 *not become operative.*

O